PHYSICIAN CLEARANCE FORM: CONCUSSION MANAGEMENT

This form must be completed and signed by the student's treating physician or another appropriate healthcare professional. In accordance with H.B. No. 2038, this signed form must be on file with the school nurse to initiate and complete the Return-To-Play (RTP) Protocol.

STUDENT NAME _____ **DATE OF BIRTH/AGE** _____

GRADE _____ **DATE OF INJURY** _____

SPORT/ACTIVITY _____ **TIME OF INJURY** _____

The student named above was referred due to displaying signs and/or symptoms of a concussion. In my professional judgment, the student may begin the RTP protocol once asymptomatic for at least 24 hours. After completing the RTP protocol, he/she is safe to return to full unrestricted sports participation.

MEDICAL EVALUATION

Date of Evaluation _____

☐ Concussion was diagnosed

☐ Concussion was not diagnosed

MEDICAL CLEARANCE

☐ The student is **NOT CLEARED** at this time and is not allowed to participate in the RTP Protocol. The student is to return to the clinic for further evaluation on: _____

☐ The student is **CLEARED** to begin the required RTP Protocol under the supervision of the athletic trainer, athletic director, coach, or school nurse. Once the student successfully completes the protocol, he/she **does not need to return** to the treating physician and is cleared for full sports participation.

☐ The student is **CLEARED** to begin the required RTP Protocol under the supervision of the athletic trainer, athletic director, coach, or school nurse. Once the student successfully completes, he/she **MUST RETURN FOR RE-EVALUATION** BEFORE BEING CLEARED FOR FULL UNRESTRICTED SPORTS PARTICIPATION.

STEP-WISE RETURN TO PLAY PROTOCOL (Student athletes will only advance ONE phase per day)

The student should be held out of all activities until asymptomatic at rest for at least 24 hours. This asymptomatic period includes mental exertion in school to help reduce the reemergence of symptoms once the return-to-play protocol is initiated.

PLEASE NOTE: If any concussion symptoms occur while returning to play, the student should stop all activity until asymptomatic for another 1-2 days. Once symptoms resolve, resume with the phase in which the student was previously asymptomatic (back to the previous successful phase).

Step 1 Light aerobic activity (10-15 minutes); NO resistance training.

Step 2 Moderate aerobic activity (20-30 minutes); Light resistance training

Step 3 Sport-specific, non-contact training drills (at least 30 minutes); Continue light resistance training; NO head impact activities or drills.

Step 4 Sport-specific, light contact training drills; Progressive return to normal resistance training.

Step 5 Full contact practice, but NO games or competition play.

Step 6 FULL participation in games or competition play (requires School Nurse clearance)

School Nurse clearance is required for full, unrestricted participation.

SPECIAL INSTRUCTIONS/RESTRICTIONS

_____

_____

CONTRAINDICATIONS TO RETURN

☐ No contraindications identified

☐ The following contraindications to return-to-play and/or school are noted:

_____

_____

RETURN TO LEARN (Academic Engagement)

☐ Student may return to full academic activities with no restrictions

☐ Student may return with the following accommodations/timeline:

- ☐ Reduced screen time
- ☐ Rest breaks during class/testing
- ☐ Extended time for assignments/tests
- ☐ Reduced workload/homework
- ☐ Modified attendance (shortened day)
- ☐ No testing until: _____
- ☐ Begin partial academic engagement on: _____
- ☐ Full academic engagement anticipated by: _____

COGNITIVE REST RECOMMENDATIONS

☐ Limit exposure to screen time, video games, and electronic devices

☐ Encourage rest in a quiet, low-stimulation environment

☐ Avoid strenuous cognitive activity (studying, reading, prolonged homework) until symptoms improve

☐ Other: _____

PHYSICIAN INFORMATION

Physician Name (print): _____ Specialty: _____

Phone: _____ Address: _____

Physician Signature: _____ Date: _____

PARENT/GUARDIAN ACKNOWLEDGMENT

I have reviewed the above information, and I understand the recommendations for my child's recovery, and agree to follow the school's concussion return-to-learn/return-to-play protocols.

Parent/Guardian Name (print): _____

Signature: _____

Date: _____